

## PRESCRIPTION DRUG DONATION PROGRAM PATIENT APPLICATION and DISPENSING FORM

 Questions about completion of this form may be directed to the Bureau of Public Health Pharmacy at (850) 922-9036.
 Patient: Please complete the top portion of this form.

PATIENT INFORMATION								
Name- Patient (Print)					Date Received (MM/DD/YYYY)		Υ)	
			Lou		0		715	
Address		City		State		ZIP Code		
Telephone number (home or work)  Telephone		l e number (cell)		Email Address				
Please indicate if you are: (check   Indigent (at or below 2   Underinsured (drug or pocket expenses for the	00% of federal phealth care bene	overty level efits have be		ed, or no drug cover	age, inclu	ding an inability	/ to af	ford the out-of-
□ Uninsured (no health o	Uninsured (no health care coverage and not eligible for drug coverage under federal government program)							
By signing below, I affirm to my eligibility changes. I also donated to the program. It disciplinary action. Eligible Attestation of Recipient (Signature)	so acknowledo Donors and page patients are	ge the fol articipants	lowing: The in the	e prescription d ogram are immu	rug or sı ne from	upply I am re civil or crimi	eceiv	ing was
Dispenser completes the below information:								
DRUG/MEDICAL SUPPLY INFORMATION								
Drug Name or Medical Supply	Strength	NDO	C No.	Lot No		Expiration Date	n	Quantity
Print Name (Dispenser) Signature (Dispenser) Date								

Submit this form to: <a href="mailto:DOH">PrescriptionDrugDonationProgram@FLHealth.gov</a> or mail to: DOH Bureau of Public Health Pharmacy, Drug Donation Program, 104-2 Hamilton Park Dr., Tallahassee, FL 32304

DH9005-EPCS-07/2021 Rule 64J-4.005, F.A.C. Effective: July 2021



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Patient Name: DRUG/MEDICAL SUPPLY INFORMATION (continued)						
Drug Name or Medical Supply	Strength	NDC No.	Lot No.	Expiration Date	Quantity	

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Patient Name:							
DRUG/MEDICAL SUPPLY INFORMATION (continued)							
Drug Name or Medical Supply	Strength	NDC No.	Lot No.	Expiration Date	Quantity		

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